COMPONENT II: Funding Opportunity F:

Breast and Cervical Cancer Control Program

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I. PROGRAM INFORMATION

A. Background

The Texas Department of Health (TDH) receives funds under a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC) to implement the Breast and Cervical Cancer Control Program (BCCCP). Since its inception, the BCCCP has screened over 145,000 women through contracts with more than 40 health care agencies at more than 300 service delivery sites. Fiscal year (FY) 2003 contractors include community health centers, local and regional health departments, family planning organizations, YWCAs, hospital districts, and university-based schools of medicine and nursing. BCCCP contractors provide client program eligibility determination and enrollment, client education, follow-up, and case management services. Most contractors also provide initial clinical breast and pelvic examinations and Pap tests onsite, although some subcontract with local health care providers to perform these services.

In addition to breast and cervical cancer screening services, the BCCCP provides training and professional education for health care providers who serve BCCCP clients through:

- funding of tuition, fees, and travel for breast and cervical cancer clinical and didactic training; and
- conferences and training updates for contractors and partners through which continuing education credits are offered.

The BCCCP partners with organizations throughout Texas to support program services for women, including the Texas Cancer Council, the American Cancer Society, Texas Division, the Susan G. Komen Breast Cancer Foundation, and many others.

B. General Purpose and Program Goals

The goal of the BCCCP is to reduce mortality from breast and cervical cancer in Texas. The BCCCP funds early detection clinical services for women at highest risk of dying from breast and cervical cancer. For breast cancer services, women at highest risk are those age 50 and older. For cervical cancer services, women who have never been screened or who have not been screened within the previous five years are at highest risk of dying from cervical cancer. African American, Native American, Hispanic, and underserved women in rural areas are also priority populations for program services.

Women age 50 and older with incomes at or below 200 percent of the federal poverty level who have no other source of payment are eligible for program–funded breast cancer screening and diagnostic services. Women under age 50 at the same income level with no other source of payment who present with symptoms suspicious for breast cancer are also eligible for program-funded diagnostic services.

Women age 18 and older with incomes at or below 200 percent of the federal poverty level who have no other source of payment are eligible for program-funded cervical cancer screening and diagnostic services. Women who have had three consecutive annual Pap tests with normal results are not eligible for program-funded cervical cancer screening during the fourth and fifth years.

To assure high quality services to clients, the BCCCP assists contractors by providing professional education for health care providers, quality assurance, data collection and analysis, case management, public education and outreach strategies, and ongoing program technical assistance and training.

C. Program Legal Authority

The BCCCP was established under the Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 USC §§201 et seq., as amended, and the Texas Breast and Cervical Cancer Control Program rules, 25 TAC §§61.31 - 61.42. The program was reauthorized under the Women's Health Research and Prevention Amendments of 1998, 42 USC §§300k-300n-5.

D. Use of Funds

In addition to the provisions described in COMPONENT I - Information, Content and Required Forms, funds are awarded for approved breast and cervical cancer screening, diagnostic, and case management services. The purpose of case management in this program is to assure timely diagnosis and initiation of treatment services for clients.

Applicants must request funds for the same services that they are currently providing: breast and cervical cancer screening, or cervical screening only. **Applicants requesting funds for cervical services only must be able to assure appropriate follow-up of women with abnormal clinical breast examinations**. Additionally, applicants must demonstrate how priority populations will be served, and are responsible for annual rescreening of program-eligible women for breast cancer. Funds may not be used to supplant local or state funds or be used for treatment, equipment, or other procedures or services not expressly identified by the BCCCP.

The BCCCP provides funding for case management under the regional and fee-for-service models. All BCCCP contractors are required to provide case management services to clients with abnormal screening or diagnostic test results.

Under the regional case management model, a lead BCCCP contractor provides staffing and oversight of case management for multiple contractors. Only applicants that are currently funded for regional case management may apply for renewal funding under the regional model. Additionally, applicants for regional case management funding must attach a letter of agreement or memorandum of understanding from each of their regional case management partner agencies.

The fee-for-service model allows billing for case management services for individual clients with abnormal screening results. Applicants not participating in the regional case management model may request funds under the fee-for-service model. Reimbursement rates for fee-for-service case management services are included in the required budget form (BCCCP Budget). **Case management funding and reimbursement is contingent upon availability of funds**.

E. Program Requirements

Program contractors must comply with Quality Care: Client Services Standards for Public Health and Community Clinics, all contractors are required to determine eligibility for the program for women prior to enrollment.

Contractors are required to determine eligibility for the program for women prior to enrollment. Contractors are also required to provide each enrolled client individualized education and screening for breast and/or cervical cancer. Contractors that are funded for breast and cervical services must provide a clinical breast examination (CBE) and mammogram. Contractors funded for cervical services only must also provide a CBE, pelvic examination, and Pap test.

Additionally, contractors must provide case management services to all clients with abnormal screening and diagnostic results. The purpose of case management is to assure appropriate follow-up of clients with abnormal results, and to assure that treatment is initiated for clients with a diagnosis of cancer. Case management includes a needs assessment, service plan, and monitoring of the plan. Case management is also designed to assist contractors in meeting the following performance measures:

- The mean number of days between abnormal CBE or abnormal initial mammography results (includes suspicious abnormality, highly suggestive of malignancy and assessment incomplete) and final diagnosis must be less than or equal to 60 days;
- The mean number of days between final diagnosis of breast cancer (*in situ* or invasive) and treatment must be less than or equal to 30 days;
- At least 90% of abnormal breast screenings or cases with a diagnostic work-up planned must have a completed diagnosis with no more than 3% lost to follow-up, 2% refused, and 5% pending. Abnormal breast screening includes mammograms with a final assessment of suspicious abnormality, highly suggestive of malignancy, or assessment incomplete, or abnormal CBE;
- The mean number of days between abnormal Pap test results (ASC-H, LSIL, HSIL, AGUS, or squamous cancer) and final diagnosis must be less than or equal to 60 days;
- The mean number of days between diagnosis of CIN II, CIN III/CIS, or invasive cancer of the cervix and treatment must be less than or equal to 30 days;
- At least 90% of abnormal cervical screenings or cases with a diagnostic work-up planned must have a completed diagnosis with no more than 3% lost to follow-up, 2% refused, and 5% pending. Abnormal cervical screening includes a Pap test result of ASC-H, LSIL, HSIL, AGUS, or squamous cancer.

The Breast and Cervical Cancer Treatment Act (Act), which assures Medicaid coverage for breast or cervical cancer treatment for clients screened or diagnosed with program funds, was implemented on December 1, 2002. The Act allows BCCCP contractors to determine presumptive Medicaid eligibility for clients in order to facilitate cancer treatment. **Each contractor must meet general TDH provisions regarding Medicaid provider enrollment.**

The BCCCP requires that renewal contractors provide breast and/or cervical cancer screening and diagnostic services to a minimum of 250 clients during the budget period July 1, 2003 through June 30, 2004.

F. Project Description

GOAL*:* The goal of the BCCCP is to reduce mortality from breast and cervical cancer in Texas.

Performance Measure Requirements. The applicant agrees that the following performance measures will be used to assess in part its effectiveness in providing the services described. The proposed target levels of performance will be negotiated and agreed upon by the applicant and the BCCCP. The BCCCP continually monitors these performance measures.

Program Funding Performance Measures:

- The unduplicated number of women served;
- The respective number of breast and cervical screening cycles;
- The percent of funds expended.

Breast Screening Performance Measures:

- At least 75% of program-funded mammograms must be provided to BCCCP eligible women 50-64 years of age;
- The mean number of days between abnormal CBE or abnormal initial mammography results (includes suspicious abnormality, highly suggestive of malignancy and assessment incomplete) and final diagnosis must be less than or equal to 60 days;
- The mean number of days between final diagnosis of breast cancer (*in situ* or invasive) and treatment must be less than or equal to 30 days;
- At least 90% of abnormal breast screenings or cases with a diagnostic work-up planned must have a completed diagnosis with no more than 3% lost to follow-up, 2% refused, and 5% pending. Abnormal breast screening includes mammograms with a final assessment of suspicious abnormality, highly suggestive of malignancy, or assessment incomplete, or abnormal CBE.

Cervical Screening Performance Measures:

- The mean number of days between abnormal Pap test results (ASC-H, LSIL, HSIL, AGUS, or squamous cancer) and final diagnosis must be less than or equal to 60 days;
- The mean number of days between diagnosis of CIN II, CIN III/CIS, AGUS, or invasive cancer of the cervix and treatment must be less than or equal to 30 days;
- At least 90% of abnormal cervical screenings or cases with a diagnostic work-up planned must have a completed diagnosis with no more than 3% lost to follow-up, 2% refused, and 5% pending. Abnormal cervical screening includes a Pap test result of ASC-H, LSIL, HSIL, AGUS, or squamous cancer.

G. Project Development

All applicants are urged to discuss their interests and ideas for developing projects early in the planning stage with state, regional, and local planning agencies and/or health departments. Community support should be assured by providing opportunities for public and private participation in the planning and development phases.

H. Program Review Process and Review Criteria

A review team using a uniform scoring instrument will score renewal applications meeting the preliminary screening requirements described in COMPONENT I - Information, Content and Required Forms. Funding awards will be based on: (1) availability of funds; (2) application scores; (3) applicant's previous program and financial performance; and (4) level of funding requested.

The BCCCP will develop a review tool based on the "Required Review Criteria" assigned to each section of this renewal application.

II. RENEWAL APPLICATION CONTENT AND BLANK FORMS

This Funding Opportunity must be developed and submitted in accordance with the instructions outlined in this section.

THIS FUNDING OPPORTUNITY MUST BE ORGANIZED AND ARRANGED IN THE FOLLOWING ORDER:

A. Description of Populations to be Served ..... FORM F2
B. Progress Report and Plans for Improvement ..... FORM F3
C. Work Plan ..... FORM F4
D. Required Budget Tables ..... FORM F5
E. Regional Case Management Budget Forms (if applicable) ..... FORM F6
F. BCCCP Professional Education Needs Assessment ..... FORM F7
G. BCCCP Staff Contact Form ..... FORM F8
H. BCCCP Service Delivery Sites ..... FORM F9
I. Memoranda of Understanding/Letters of Agreement or for Regional Case Management Applicants

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FORM F1: RENEWAL APPLICATION CHECKLIST

Legal Name of _____

INSTRUCTIONS: This Checklist may be completed and submitted with the original renewal application. It is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications and attachments have been submitted. Application is typed (computer or typewriter), single-spaced on 8 ½ " x 11" white paper and does not exceed page limits where specified. Confidential information is clearly marked in the application and reasons the information should be confidential are stated.

FORM	REQUIRED COMPONENT I FORMS	Included	Not Applicable
1	Face Page completed, and proper signatures and date included		
2	Contact Person (Administrative and Program) Information included		
3	Administrative Information (with supplemental documentation attached if required) included		
4	Medicaid Provider Status Table completed and included if Titles V (Fee), X, or XX applicant		
5	Nonprofit Board of Directors and Executive Director Assurances form signed and included		
6	Copy(ies) mailed to appropriate Regional Director for proposed area(s) to be served		

FORM	FUNDING OPPORTUNITY F – Breast & Cervical Cancer Control Program	Included	Not Applicable
F2	Description of Populations to be Served completed and included		
F3	Progress Report and Plans for Improvement completed and included		
F4	Work Plan completed and included		
F5	Required Budget Tables completed and included		
F6	Regional Case Management Budget Forms completed and included		
F7	BCCCP Staff Professional Education Needs Assessment completed and included		
F8	BCCCP Staff Contact form completed and included		
F9	BCCCP Service Delivery Sites completed and included		
	Memorandum of Understanding/Letters of Agreement for Regional Case Management Applicants		

FORM F2: DESCRIPTION OF POPULATIONS TO BE SERVED

Provide an estimate of the number of unduplicated clients to be served and screening cycles to be performed during the budget period. **Note: Each applicant must propose to serve a minimum of 250 unduplicated** clients. Projected breast cancer screening services must be categorized by age and cervical cancer screening services must be categorized by "never or rarely screened" status. Breast and cervical cancer screening services must be categorized by race/ethnicity.

1. Agency Name: _____

2. Counties to Receive Services: _____

_____

3. List of Service Delivery Sites: _____
(On Form F9, complete additional information on each service delivery site)

_____

4. Proposed Screening for July 1, 2003 through June 30, 2004

Breast Screening*

Age	# Unduplicated Clients**	# Screening Cycles***
50-59		
60-64		
Total		

*Clinical breast exam and mammogram
**Estimated number of individual clients to be screened
***Estimated number of screening cycles – include all annual screening, short-term follow-up, and referrals into your program in this figure. **This number will be greater than the number of unduplicated clients.**

Cervical Screening*

Screening History	# Unduplicated Clients**	# Screening Cycles***
Never Screened		
Screened 5 years		
Screened < 5years		
Total		

*Clinical breast exam, pelvic exam, and Pap test
**Estimated number of individual clients to be screened
***Estimated number of screening cycles – include all annual screening, short-term follow-up, and referrals into your program in this figure. **This number will be greater than the number of unduplicated clients.**

FORM F2: DESCRIPTION OF POPULATIONS TO BE SERVED, continued

Agency Name: _____

5. Prioritize the population(s) to be served by race/ethnicity. In the appropriate column indicate the number of individual women to be served and the corresponding percentage.

Breast Cancer Services		
RACE	**Number of Women**	**Percentage**
White		
Black/African American		
Hispanic		
Asian/Pacific Islander		
American Indian/Aleut		
Other		

Cervical Cancer Services		
RACE	**Number of Women**	**Percentage**
White		
Black/African American		
Hispanic		
Asian/Pacific Islander		
American Indian/Aleut		
Other		

FORM F3: PROGRESS REPORT AND PLANS FOR IMPROVEMENT GUIDELINES

Applicant must respond to the required review criteria below when providing updates on progress toward meeting program goals and objectives. The BCCCP state office has provided each contractor with data to assist in responding to the criteria. All applicants must respond to criteria 1-5 and 7-9. **Only regional case management applicants** will respond to criterion 6.

Required Review Criteria (applies to period September 1, 2001 – September 30, 2002)

1. Describe your organization's progress in assuring that 75% of Program-funded mammograms were provided to women age 50-64. If your organization did not meet this requirement, please explain the reasons and concisely describe your plan for improvement. **Limit response to one-half page.**

2. Describe your organization's progress in assuring that 20% of women screened for cervical cancer had never been screened or had not been screened within the previous five years. If your organization did not meet this requirement, please explain the reasons and concisely describe your plan for improvement. **Limit response to one-half page.**

3. Describe your organization's progress in assuring diagnosis and treatment of clients within the program's required time frames (60 days screening to diagnosis; 30 days diagnosis to initiation of treatment). If your organization did not meet these requirements, please explain the reasons and concisely describe your plan for improvement. **Limit response to one page.**

4. Describe how your agency will assure treatment of women who do not qualify for Medicaid services under the Breast and Cervical Cancer Treatment Act. **Limit response to one page.**

5. Describe your progress in serving the projected number of women. If you did not reach your goals, describe the barriers that you encountered. **Limit response to one-half page.**

6. List the collaborating BCCCP agencies that will be involved in the partnership for case management, the geographic area, and the lead agency. Include a letter of agreement or memorandum of understanding for each BCCCP contractor included in the partnership **(for regional case management contractors only)**.

7. Describe your BCCCP staff's professional education needs. On Form F7, list the names and credentials of staff that will need professional clinical training. Use additional pages if necessary.

8. On Form F8, list the BCCCP contact personnel for your organization.

9. On Form F9, list your service delivery sites, their addresses, phone numbers, and the name and e-mail address of a BCCCP contact person at each site. This information will be used to update the BCCCP website. Use additional pages if necessary.

FORM F3: PROGRESS REPORT AND PLANS FOR IMPROVEMENT

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

Applicant must provide a response for each review criterion (see Progress Report and Plans for Improvement). **You may use this form repetitively for each item listed in Form F3 guidelines, limiting responses to page requirements.**

FORM F4: WORK PLAN

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

Applicant must complete the table below for each of the following program components: (1) screening (2) case management and follow-up (3) outreach (4) public education (5) staff training and professional education (6) data and billing submission, and (7) partnerships and collaborations**.** Objectives and activities should be linked to performance areas needing improvement, as indicated in the Progress Report Form F3. **Add additional pages, if necessary.**

Agency: _____

Goal: _____

Objectives*	Activities	Measurement	Staff Responsible	Completion Date

***Must be measurable.**

FORM F5: INSTRUCTIONS FOR COMPLETING BUDGET TABLES

The applicant must submit four budget tables to the Breast and Cervical Cancer Control Program to be considered for funding:

1. Budget Table A. Clinical Procedures
2. Budget Table B. Fee-For-Service Case Management Procedures **(to be completed by fee-for-service case management applicants only)**
3. Budget Table C1 – C2. Matching Contributions
4. Budget Table D. Total Budget Request (including support services costs)

Each BCCCP grant award for screening, diagnostic, and fee-for-service case management services is reimbursed on a fee-for-service basis. Contractors receive reimbursement upon submission of documentation on the completion of approved procedures.

Each BCCCP grant award for regional case management services is awarded on a categorical basis.

Instructions for Budget Table A. Clinical Procedures

Applicants must submit Budget Table A to request funds for breast and cervical cancer screening and diagnostic services. The rates for clinical procedures are based on federal requirements. Higher reimbursement rates cannot be negotiated.

For breast and cervical cancer screening clinical procedures, an appropriate budget level is determined by estimating how many breast and cervical cancer screenings will be conducted within the 12-month budget period. Please review the list of approved procedures. Only procedures listed on Table A are eligible for reimbursement. The BCCCP will provide each applicant data from 2002 and instructions to assist with estimating service levels.

Instructions for Calculating Support Services Costs

Applicants may request **up to ten percent (10%) of the total amount requested for clinical procedures** to recover costs associated with providing program services.

Instructions for Budget Table B - Fee-For-Service Case Management

Applicants must submit Budget Table B to request funds for fee-for-service case management reimbursement. The number of case management services will equal the number of clients with abnormal screening results.

Instructions for Budget Table C - Matching Contributions

List and describe each non-federal matching contribution provided by your agency and the amount of the match below. Use additional pages if necessary. **Matching contributions will be reported to the CDC and must be reported by each applicant.** In order to qualify as a satisfactory match the proposed item(s) must qualify as an item(s) that could be covered under the federal program. The enabling legislation for the Program requires at least $1 in match for every $3 awarded to Texas.

Instructions for Budget Table D - Total Budget Request

Use this table to summarize your requested totals for clinical services, fee-for-service case management, support services, regional case management (if applicable) and your proposed matching contribution for screening and diagnostic services.

FORM F5: INSTRUCTIONS FOR COMPLETING BUDGET TABLES, continued

For Regional Lead Case Management Contractors

Refer to Appendices A and B (Budget Summary Instructions and Detailed Budget Category Forms) in COMPONENT I, SECTION IV. REQUIRED BLANK FORMS AND INSTRUCTIONS. The regional case management budget request must be submitted on the Budget Summary and the appropriate Detailed Budget Category Forms (FORM F6). List your matching contributions for case management funds on FORM F9 - Required Budget Tables, Table C-2.

FORM F5: REQUIRED BUDGET TABLES

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

BUDGET TABLE A. CLINICAL PROCEDURES

	CPT Code	Reimbursement	Number of Procedures	Total
Screening Mammogram	76092	$80.48		
Office Visit – New Patient Only - 10 minutes	99201	$33.77		
Office Visit – New Patient Only - 20 minutes	99202	$61.28		
Office Visit – New Patient Only - 30 minutes	99203	$91.64		
Office Visit - Established Patient; face-to-face - 10 minutes	99212	$35.89		
Office Visit - Established Patient; face-to-face - 15 minutes	99213	$49.94		
Office Visit - Established Patient; face-to-face - 25 minutes	99214	$78.26		
Office Visit - Breast Consultation only, 15 minutes	99241	$46.87		
Office Visit - Breast Consultation only, 30 minutes	99242	$87.15		
Office Visit - Breast Consultation only, 40 minutes	99243	$114.46		
Office Visit - Breast Consultation only, 60 Minutes	99244	$163.73		
Diagnostic Mammogram (unilateral)	76090	$76.48		
Diagnostic Mammogram (bilateral)	76091	$94.21		
Aspiration of Breast Cyst	19000	$77.98		
Aspiration of each additional cyst	19001	$46.64		
Needle core breast biopsy	19100	$102.88		
Facility fee with needle core biopsy	19100-F	$333.00		
Percutaneous needle core, using imaging guidance	19102	$257.77		
Incisional breast biopsy	19101	$319.19		
Excisional breast biopsy	19120	$421.20		
Facility fee with excisional biopsy	19120-F	$510.00		
Excision of breast lesion/ preoperative placement	19125	$448.64		
Each additional lesion	19126	$161.33		

FORM F5: REQUIRED BUDGET TABLES, continued

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

BUDGET TABLE A. CLINICAL PROCEDURES (cont'd.)

	CPT Code	Reimbursement	Number of Procedures	Total
Radiological examination, surgical specimen	76098	$23.76		
Ultrasound-echography - breast, unilateral or bilateral	76645	$67.19		
Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	76942	$91.42		
Fine Needle Aspiration	10021	$83.31		
Interpretation and Report of Fine Needle Aspiration	88173	$111.30		
HPV, Papillomavirus, human amplified probe technique*	87621	$49.04		
Pathology (breast or cervical)	88305	$86.70		
Pap Smear - physician's interpretation (Bethesda System)	88141	$14.76		
Pap Smear - cytologist's interpretation (Bethesda System)	88164	$14.76		
Pap Smear - liquid based (Bethesda System)	88142	$14.76		
Colposcopy	57452	$99.38		
Colposcopy with Biopsy	57454	$117.15		
GRAND TOTAL				

*****New procedure, TDH approval pending

ALL RATES AND PROCEDURES ARE SUBJECT TO APPROVAL BY CDC

FORM F5: REQUIRED BUDGET TABLES, continued

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

BUDGET TABLE B. FEE-FOR-SERVICE CASE MANAGEMENT

	CPT Code	Reimbursement	Number of Procedures	Total
Case management for abnormal breast cancer screening, (abnormal CBE or mammogram, diagnostic tests required)	87621	$100.00		
Case management for abnormal breast cancer screening, diagnosed within 60 days (must include 99910)	99911	$50.00		
Case management for abnormal cervical cancer screening (diagnostic test required)	88810	$50.00		
Case management for abnormal cervical cancer screening diagnosed within 60 days (with 88810)	88811	$25.00		
GRAND TOTAL				

*****New procedure, TDH approval pending

ALL RATES AND PROCEDURES ARE SUBJECT TO APPROVAL BY CDC

FORM F5: REQUIRED BUDGET TABLES, continued

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

BUDGET TABLE C-1. MATCHING CONTRIBUTION (screening and diagnostic services only)

Description – Breast and Cervical Screening and Diagnostic Match	Amount

BUDGET TABLE C-2. MATCHING CONTRIBUTION (case management only)

Description - Case Management Match	Amount
TOTAL	

FORM F5: REQUIRED BUDGET TABLES, continued

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

BUDGET TABLE D. TOTAL BUDGET REQUEST AND MATCH CONTRIBUTION

Total Request for Clinical Procedures (Table A)	
Total Request for Support Services Cost (max 10% of clinical procedures request)	
TOTAL CLINICAL REQUEST	
Total Request for Fee-For-Service Case Management (Table B)	
Total Request for Regional Case Management (current lead case management contractors only)	
TOTAL CASE MANAGEMENT REQUEST	
GRAND TOTAL REQUESTED (Clinical and Case Management)	
Screening Match Contribution (Table C-1)	
Case Management Match Contribution (Table C-2)	
TOTAL MATCH CONTRIBUTION	

FORM F6: BUDGET SUMMARY

Legal Name of Applicant: _____

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$
B. Fringe Benefits	$	$	$	$	$	$
C. Travel	$	$	$	$	$	$
D. Equipment	$	$	$	$	$	$
E. Supplies	$	$	$	$	$	$
F. Contractual	$	$	$	$	$	$
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A
H. Other	$	$	$	$	$	$
I. Total Direct Costs	$	$	$	$	$	$
J. Indirect Costs	$	$	$	$	$	$
K. Total (Sum of I and J)	$	$	$	$	$	$
L. Program Income - Projected Earnings	$	$	$	$	$	$

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM F6-6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Contract Policy and Management Division.

☐ Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM F6-7).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM F6-1: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required.

Salary Total	$
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

FORM F6-2: TRAVEL Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
TOTAL for Conf/Workshop TRAVEL:				$	$	$	$	

Local TRAVEL Costs: $	**Conf/Workshop TRAVEL Costs:** $	**Total TRAVEL Costs:** $

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

FORM F6-3: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g. $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$	

FORM F6-4: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for SUPPLIES: $

FORM F6-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $

FORM F6-6: OTHER Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$

FORM F6-7: INDIRECT COST Budget Category Detail Form

Legal Name of Applicant: _____

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
Total Amount Requested for INDIRECT COST:	$

FORM F7: BCCCP STAFF PROFESSIONAL EDUCATION NEEDS ASSESSMENT

Legal Name of Applicant:____

Prepared by:__________________________________ **Phone Number:** ______________

In the table below, list the names of staff that need clinical training. Next to their names, indicate which modules each person needs to attend by placing a check mark in the cell.

Staff Information	Clinical Training Modules			Didactic Training		
	Breast Cancer	Breast and Cervical Cancer	Colposcopy (physicians, N.P., P.A. only)	Cervical Cancer	Breast Cancer	Other-Explain
Staff Name:_________________ **Credentials (R.N., N.P., P.A., etc.):**_________ **Phone:**_________________ **Fax:**_________________ **E-mail:**_________________						
Staff Name:_________________ **Credentials (R.N., N.P., P.A., etc.):**_________ **Phone:**_________________ **Fax:**_________________ **E-mail:**_________________						
Staff Name:_________________ **Credentials (R.N., N.P., P.A., etc.):**_________ **Phone:**_________________ **Fax:**_________________ **E-mail:**_________________						
Staff Name:_________________ **Credentials (R.N., N.P., P.A., etc.):**_________ **Phone:**_________________ **Fax:**_________________ **E-mail:**_________________						

FORM F8: BCCCP STAFF CONTACT FORM

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

This information is needed to ensure that the correct contractor staff receives key/important and or relevant BCCCP information. If there is not an assigned contact please write "not applicable" by name.

Executive Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Program Coordinator/Director Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Case Manager Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Outreach Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Billing Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Data Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Public Information Contact
Name: _____ Title: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

FORM F9: BCCCP SERVICE DELIVERY SITES

Legal Name of Applicant:_____

Prepared by:_____ **Phone Number:** _____

Provide your web site address if applicable. Also, write the name and contact information of all your clinic sites. This information is needed to provide correct referral information to callers and to update the BCCCP website.

Contractor Name:_____ **Do you have a Web Site: ___yes ___no**

If yes, please indicate your Web Site/Address:_____

Contractor Provider/Clinic Sites

Name of Clinic	Address	Phone/Fax	E-Mail	County
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		
		Phone: **Fax:**		

Memoranda of Understanding/
Letters of Agreement
for Regional Case Management Applicants